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HEALTH REFORM IMPLEMENTATION COUNCIL INITIAL RECOMMENDATIONS
FEBRUARY 7, 2011

The Illinois Hospital Association (IHA) and its 200 member hospitals and health systems are strongly committed to their partnership with the state to both sustain the health care delivery system in the short term and to transform it in the long term. During the transition, the state must take a balanced and thoughtful approach to implementing health care reform, with vigorous and widespread input by all affected parties throughout the process. We look forward to putting Illinois on the map as a premier state for health care quality and patient safety as well as working with the state to create sound public policy facilitating tomorrow's supply of qualified and participating health care professionals.

Hospitals are well-positioned to partner with the state to build on current mutual strengths as we move forward with reform. IHA is committed to supporting the state's implementation of the Patient Protection and Affordable Care Act (ACA) and efforts for a successful transition to a new and improved health care delivery system and patient experience in this state. We urge the Council and the state to engage IHA and the hospital community as true partners in this critically important work.

IHA appreciates this opportunity to offer its comments to the "Initial Recommendations of the Health Care Reform Implementation Council" (January 31, 2011), which were released on February 3, 2011.

Recommendations We Support:

First, we appreciate and express our support for many of the Initial Recommendations offered by the Council. Specifically, we support the initial recommendations identified as "Immediate Issues" in the report that are included under the following subject headings:

- Establishment of an American Health Benefits Exchange
- Establishment of the Exchange as a quasi-governmental entity
- Internal Appeals and External Review
- Minimum Medical Loss Ratio Requirements
- Health Care Cooperative Program (CO-OPs)
- Mental Health Parity
- Eligibility Verification and Enrollment in Coverage

Recommendations Requiring Further Consideration:

We respectfully urge the Council to give further consideration to and revise several recommendations in order to strengthen them or to resolve potential challenges that would undermine the health care delivery system. Our concerns and suggestions (**in bold**) about those recommendations are as follows.

PART ONE: Recommendations – Immediate Issues

B1: Operating Model

While we generally agree with the approach taken by the Council relating to the establishment of an Exchange, IHA is concerned that the proposed approach to the Exchange's operating model will have the exact opposite effect than anticipated by the Council. Specifically we believe establishing an "active purchaser" model first will reduce consumer access to appropriate plans, reduce insurer competition, increase the costs of administering the Exchange, and could result in rate controls not appropriate to evolving Exchange markets. We believe the restrictions imposed by the medical loss ratio requirements and federal and state rate oversight are adequate to ensure rate competition. Establishing barriers to insurers will likely lead to fewer players in the Exchange and reduced consumer selection. If there is a concern about too many consumer choices, insurers could be limited to one or two plans per benefit level in the Exchange. **IHA believes the "market organizer" model is more suitable to a fully functioning and vibrant Exchange.**

B4: Financial Sustainability

We fully support the continued dialogue on financing the Exchange, but caution against establishing new fees on providers and other stakeholders without knowing how much the Exchange would cost. We would urge the Council to consider existing funding mechanisms with known parameters; specifically we believe **the existing HIPAA-CHIP assessment on insurers should be converted to funding the Exchange.** Not only will insurers benefit financially from the elimination of the HIPAA-CHIP plan once the Exchange is operational, they will also benefit from an estimated 200,000 to 300,000 additional enrollees through the Exchange while avoiding any of the negative costs associated with the estimated 800,000 to 1,400,000 uninsured Illinoisans that will receive coverage through Medicaid or remain uninsured.

PART TWO: Recommendations – Other Critical Issues and Next Steps

B1: Consumer Outreach, and B2: Role of Navigators and Producers

We agree with the Council's recommendation for the state to develop an aggressive outreach plan to assist individuals in enrolling in health plans. IHA believes hospitals will continue to play an important role in consumer education and should not be excluded from acting as navigators given that hospitals will often be the first place consumers will confront the concept of the Exchange. Therefore, **we ask that reference to the role of providers be inserted into both B1 and B2.**

C: Healthcare and Public Health Workforce

A robust health care workforce is essential to enabling the health care system to meet the needs of all Illinoisans and to keeping local and state economies strong. IHA strongly supports the recommendations for workforce as outlined in the Council's report for addressing shortages, especially those that coordinate workforce education and training among area educational institutions, economic development agencies and employers. We are most appreciative of the state evaluating Illinois' current scope of practice laws to eliminate barriers in order that all professionals may provide patient care services to the full extent of their education, skills and clinical experience. While the report's recommendations are appropriate measures for addressing workforce development, there are others that should also be included.

Illinois hospitals, as key employers and providers of essential patient care services, have a vested interest in the health of our state's current and future workforce. As such, **we strongly encourage that hospitals are included as critical members of the state's workgroup addressing this issue.**

In addition, **the collection and analysis of ongoing, objective Illinois-specific data to assist the workgroup's efforts for addressing health care education and workforce development is essential.** Analyzing trends in supply, demand, distribution and use of health care workers in conjunction with our state's educational resources is critical. Without accurate information, efforts to implement effective strategies for development and training to meet our state's health care needs will be left to costly and inefficient "hit or miss" approach. Illinois' Center for Nursing efforts on data offer a viable model to extend to other health care professionals.

Projected physician shortfalls heighten concerns about patient access to physician and primary care services across Illinois. A recent 2010 Illinois study concluded that nearly one-half of graduating Illinois physician residents and fellows are leaving the state to practice. The medical malpractice liability environment was cited as a major reason for those planning to leave Illinois and practice in other states. **Addressing the critical need for medical liability reforms must be part of discussions for recruiting and retaining physicians in Illinois.**

D: Health Information Technology

The Illinois Hospital Association is long-time advocate and supporter of advancing electronic health records and health information technology to benefit patients and communities through quality improvement and administrative simplification. The road to achieving "meaningful use" remains a major challenge, with many hospitals unable to begin the journey until the state's Medicaid Electronic Health Records (EHR) Meaningful Use incentive plan is activated. The intent of the federal laws on EHRs and Meaningful Use is to provide incentives for targeted quality improvement areas while driving EHR adoption**.** However, in direct contradiction to that intent, the Illinois Department of Healthcare and Family Services (HFS) has sought to put up roadblocks to EHR and HIT implementation by making the EHR/HIT incentive payments contingent on a hospital's participation in certain managed care programs. Imposing a set of new and unrelated requirements will serve only to prevent hospitals from keeping pace with the rest of the country in adopting EHRs, Health Information Technology, and Health Information

Exchanges. **We urge HFS to drop these new requirements for receiving federally funded EHR/HIT incentive payments that are unrelated to the original purpose of those payments.**

To achieve the goal of turning data into useful information, the notion of an all payer claims database (known as APCD), is helpful for reducing costs of care and improving quality of care if it is available to those that can readily affect care – specifically, hospitals and other clinical providers. **Any development of an APCD should require the formation of an oversight council made up of state agency heads, providers, and consumers to ensure that access to information is readily available under HIPAA, HITECH, and other privacy and security measures.**

E: Incentives for High-Quality Care

The U.S. Centers for Medicare and Medicare Services' Value Based Purchasing Program, Hospital Preventable Readmission Reduction Program, and Preventable Hospital-Acquired Conditions have been carefully developed by the federal government to ensure that the methodologies, measurements, and expected changes in processes or outcomes would occur. Additionally, the federal government provides educational support and training resources to ensure that all providers are aware of the changes, with the goal of improving care – for all people who are under care in a hospital, nursing home, surgical center, diagnostic center, Renal Dialysis center, home health, and physician office. Measurements have been carefully developed with expert panels and are maintained through public vetting of measurements and public comment periods.

We encourage the state to adopt and implement the federal government's quality care initiatives for its own health program to leverage the state's limited resources and experience in launching quality incentive programs. The state should utilize national measurements for public reporting and performance payment as they have been tested, publicly vetted, and adopted by many organizations. Most commercial health plans already utilize nationally adopted health care measurements so they are able to determine performance compared to other plans nationwide as well as allow consumers to make useful and meaningful comparisons on processes and outcomes of care.

F: Reforms to Medicaid Service Structures and Incentives

The hospital community, as the state's partner in not only providing, but also financing the care to the more than 2.7 million Medicaid beneficiaries, agrees with the Council's report that the current payment system is antiquated and needs to be both updated and adequately funded. That said, neither the ACA nor the recently enacted Medicaid reform legislation (HB5420) intend for the state to simply enroll recipients in full-risk capitated HMOs. While the ACA contemplates a transition to a health system where providers are more at risk, more integrated and more accountable, it recognizes that this transformation cannot happen overnight. For example, the development of Accountable Care Organizations (ACOs) – the most significant delivery system reform in the ACA – will begin with these provider owned organizations furnishing care to Medicare beneficiaries on a shared savings basis. Similarly, the Illinois General Assembly expressed a similar intent when enacting the Medicaid reform legislation.

Rather than simply focusing on trying to transfer risk to other entities or providers, **the focus of Medicaid reform must be on the integration of the delivery of care through a variety of care coordination strategies.** These would include patient centered medical homes, shared risk models, and shared savings models. The focus should be on access to and quality of care so that Medicaid beneficiaries are assured the best possible outcome in a cost effective manner. **Testing a variety of care coordination models will enable success over the long term. IHA welcomes the opportunity to participate on the System Design work group recommended by the Council to identify, prioritize and seek financing for Medicaid program reforms.**

G: Early Medicaid Expansion

While we agree with the Council that Illinois not apply for a federal waiver to expand Medicaid prior to 2014 unless the General Assembly lifts the recent moratorium on eligibility expansion, **we would encourage the Council and HFS to continue to explore, evaluate and report any new expansions that will save state dollars.**

One population that should be considered for such an expansion are single adults with incomes below 133% of FPL who currently are receiving state only funded behavioral health services. Over the past several years, hospitals in Illinois have been serving a large and steadily increasing number of persons with mental health and substance abuse illnesses – who did not qualify for Medicaid or Medicare – in their emergency departments, inpatient beds and specialty facilities. Individuals with mental illnesses often go to the hospital emergency room in crisis because treatment was not available to them sooner and in a more appropriate setting. This unnecessarily drives up health care costs.

The U.S. Surgeon General, the Institute of Medicine and the President's New Freedom Commission on Mental Health have all concluded that primary medical and specialty psychiatric care should be integrated. They note that mental illnesses are treatable diseases, and in many cases, occur concurrently with medical conditions. For example, one-fifth of persons hospitalized for cardiac conditions have depression. Persons with serious mental illnesses die at a much younger age than the general population because of untreated medical conditions.

The situation has only worsened over the past few years, as Illinois' community mental health and substance abuse systems have sustained major funding cuts, depleting the availability of services in communities across the state. The expansion of the Medicaid program presents an opportunity for the state to enhance and rebuild community-based services, thus reducing unnecessary utilization of hospital emergency rooms and inpatient psychiatric services, and costs.

Conclusion

Thank you for this opportunity to share our reactions to the Council's Initial Recommendations. IHA and its 200 member hospitals and health systems welcome the opportunity to continue working with the Council and the state to implement the Accountable Care Act and transform our health delivery system.

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